Healthcare Leadership Councils

Summary of Findings

Prepared for the Washington state Office of Insurance Commissioner

April 2009

Milliman

Leadership council members were asked,

"If you had one clear message for the legislature, what would you say to them?"

Here's what they said:

"Fundamentally change the way healthcare is delivered in this state or we have just put on a Band-Aid."

"I'm sick and tired of just talking about this; we've got to do something!"

"This has to happen!"

"Whatever you do, cover everyone in Washington state with some form of care that is evidence-based."

"Clarify our vision/goal at the state level and implement something that meets the goal."

"We can't wait for a national solution."

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BACKGROUND

In 2008, the Washington state Legislature passed Engrossed Substitute SB 6333, which called for an economic analysis of five healthcare proposals and the formation of a Citizens' Work Group on healthcare reform. The timeline dictated by the legislation for completion of the economic analysis was by year end 2008; the public engagement work of the Citizens' Work Group was to begin no sooner than January 31, 2009, with recommendations to the legislature in time for the 2010 session.

Insurance Commissioner Kreidler felt strongly that the public engagement component should not wait until 2009 to begin and decided to convene several leadership councils across the state to gather input, advice and direction from opinion leaders in various Washington state communities. As of the publication of this report, Governor Gregoire has not taken action on the Citizen's Work Group component of ESSB 6333 due to budget contraints. This makes the discussions, debates and exchange of information and viewpoints of the Commissioner's leadership councils all the more important for informing policy makers on healthcare reform in both Washington state and Washington D.C.

Insurance Commissioner Kreidler convened leadership councils and hired Milliman to gather input, advice and direction from opinion leaders across the state regarding healthcare reform.

In addition to exploring general values and principles of healthcare reform, the Commissioner was interested in gathering specific feedback regarding the following five proposals that have been under consideration by the legislature.

PRIVATE INSURANCE DEREGULATION REFORM

Proposal 1 would modify insurance regulations in Washington state for products sold to small groups and young adults. Specifically, it would authorize health plans that do not include mandated benefits; and it would allow carriers to pool the health risk of young adults seperately from other enrollees.

THE CONNECTOR PLAN

Proposal 2 would include many components of Massachusetts' 2006 reforms. It would merge the small group, association and individual markets; all residents would be required to obtain coverage, but would be exempted from this requirement if coverage was deemed unaffordable. The Connector Plan would foster full portability of coverage in the merged market, and subsidies would be available to all individuals with incomes below 200% of the federal poverty level, although a specific funding source was not identified.

WASHINGTON HEALTH PARTNERSHIP PLAN

Proposal 3 would cover all Washingtonians with a comprehensive standardized benefit package through a program similar to what public employees currently enjoy. Enrollees would choose among participating

carriers, networks or a fee-for-service option, and would pay any premiums equal to the difference between the lowest-cost plan and the plan they choose. Participation in the lowest-cost plan would be fully paid by an assessment on payroll paid by employers, employees and self-employed individuals. Eligibility for Medicaid and SCHIP would be expanded.

SINGLE PAYER PLAN

Proposal 4 would establish a single payer system that would replace all nonfederal sources of coverage. The plan would automatically enroll all eligible residents. No specific source of funding was proposed.

GUARANTEED HEALTH BENEFIT PLAN

Proposal 5 would create a guaranteed health benefit plan that would provide limited preventive care and catastrophic coverage for all medical costs over $10,000 in a year's time to all residents of Washington. The program would be financed by a graduated payroll tax on employers and self-employed workers (smaller businesses would pay a lower rate than large business) and a flat payroll tax on employees. Individuals and businesses could then choose among a variety of basic or routine healthcare plans for coverage below the $10,000 threshold.

OBJECTIVES

The leadership councils brought together people from many sectors – physicians, mayors, small and large business leaders, tribal representatives, etc.

Milliman facilitated two rounds of discussions with leadership council members to better understand local opinion leaders' thoughts and perceptions on healthcare reform in Washington state. The objectives were to learn:

- Basic values and principles considered critical for effective healthcare reform in Washington state
- What level of coverage should be offered and to whom, who would pay for it and how would it be paid
- Perceptions and opinions of the five proposals under consideration in the Washington state legislature
- Their view of the state's role in healthcare reform
- Differences in perceptions, if any, among community sectors – healthcare, large and small businesses, civic and community
- Differences in perceptions, if any, due to geographic location.

The insight members gave was enriched by the ability to hear different perspectives on both the challenges and potential solutions to reform on the state level.

METHODOLOGY

Milliman was hired to facilitate two rounds of group discussions (each three hours in length) with the representatives from key stakeholders and opinion leaders in communities throughout the state of Washington, including:

- Hospital administrators
- Small business owners
- Large employers (including CEOs, CFOs and VPs of Human Resources)
- Family physicians
- Registered nurses
- County commissioners
- Mayors
- City council members
- Public health officers
- Tribal representatives
- Members of the community.

When members reflect different perspectives, group discussions can yield rich, qualitative data – narrative that is both interesting and insightful. This method allows for probing and face-to-face interaction, which inevitably leads to a better understanding of the members' perceptions and opinions.

To maintain objectivity during the discussions (important because one of the five proposals we were evaluating and reviewing was the Commissioner's), the facilitator and note-taker, both from Milliman, were the only people in the room other than the council members. The note-taker captured comments as the conversations unfolded. Members were reassured that no names would be attached to any comments. Comments were color-coded based on the sectors (healthcare, business, community and civic) represented.

Milliman facilitated discussions with 123 council members in 14 separate 3-hour meetings across 7 locations.

The first round of discussions were held in September and October of 2008; the second in February and March of 2009. The groups were appropriately diverse; considering both rounds of discussions, we involved the following number of members from these key sectors:

- 46 members – healthcare
- 46 members – business
- 50 members – community
- 51 members – civic.

The findings in this report are based on data from 123 members in 14 separate discussions. Two rounds of discussions were held in these seven locations throughout the state:

- Central Washington
- Columbia Basin
- Greater Seattle
- Northwest Washington
- Olympic Peninsula
- South Sound
- Spokane Valley.

LEADERSHIP COUNCIL MEMBER SELECTION

Leadership council members were invited personally by the Commissioner. The OIC staff developed a potential list of invitees for each of the seven locations, striving for balance between the different sectors: healthcare, business, community and civic. The lists were developed through conversations with leaders in those local communities about who they felt needed to be at the table for this kind of discussion. Their particular viewpoints did not factor into the selection, but the ability to be thoughtful and open to other perspectives was a criterion the OIC used.

In preparation for the first round of discussions, the OIC staff continued to invite members until 18-20 people for each location confirmed attendance. (123 people total did attend.) During round two, typical scheduling conflicts (and, in one case, a remote location) meant 70 people were able to attend. In nearly all cases, the members who attended the second round of discussions were the same as those who attended the first round.

SUMMARY OF FINDINGS – ALL COUNCILS

This section of the report shares a summary of the findings across all groups. Patterns or commonalities were of particular interest and are noted throughout.

WHERE TO BEGIN

Leadership council members were asked where they would start if tasked with healthcare reform in Washington state – begin with an existing program (for example, Basic Health Plan) and expand it or create something different. During the first round, they were more likely to suggest an entirely new delivery system – appropriate given that the discussion was less bound by what was likely or plausible. During the second round, encouraged to be realistic and discuss what was doable, they appreciated that two of the proposals referenced Public Employee Benefits (one specifically referenced the Uniform Medical Plan) as the primary coverage to be offered. The

proposals were perceived favorably, in part, because these existing plans are seen as comprehensive and valuable.

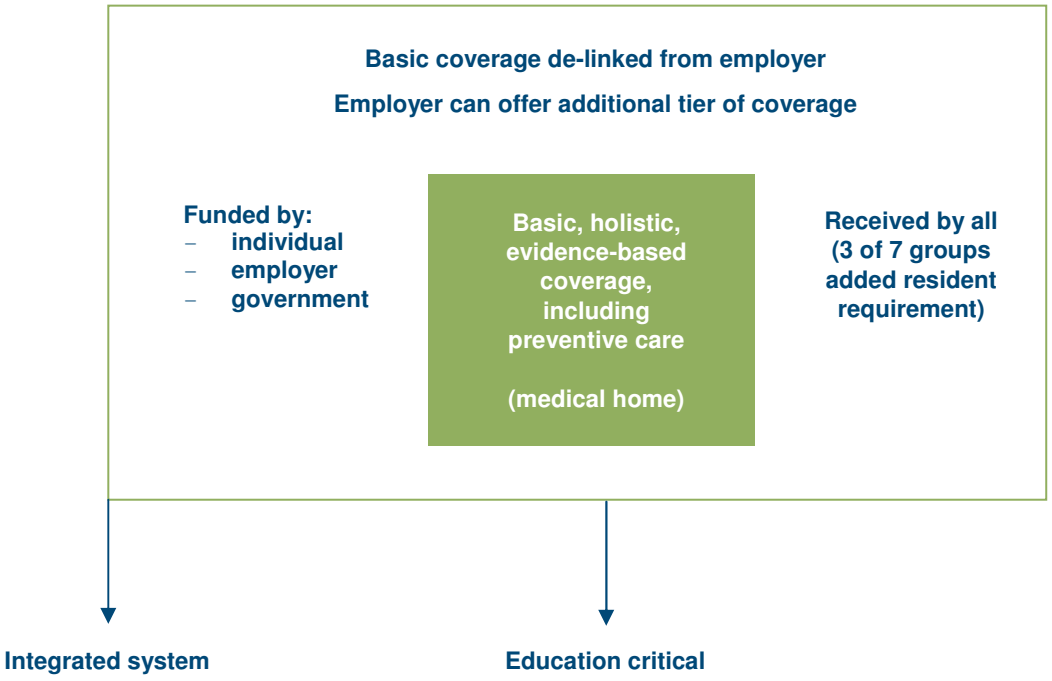
CRITICAL ELEMENTS OF AN IDEAL HEALTHCARE PROGRAM

During round one, participants were asked to think beyond the practical limitations and discuss what the ideal healthcare program would look like. We brainstormed the level of coverage as well as specifically who would receive it and pay for it. The diagram below represents elements of this discussion that were common across all councils.

Most leadership council members recommended covering everyone in Washington state.

First, and most notable, was each council's resistance to designing "just another healthcare plan." The concern was that another plan would be a Band-Aid – that it would not address the underlying inefficiencies and waste in the current system and would not deal with the currently-ineffective delivery of care.

Critical Elements of an Ideal Healthcare Program



"Unless everyone is covered, we can't put in place a system that creates efficiencies and drives down the cost of healthcare."

- Community representative

ELIGIBILITY

Most leadership council members were in favor of covering everyone in Washington state. They had mixed reactions about whether the covered person must be a state resident. Some were in favor of allowing anyone crossing the state borders to receive care (as they do now through the emergency rooms), and others said if state residence was a requirement, it would prevent an influx of people from other states crossing the borders for care.

There were a few members in several of the councils who raised a concern over covering undocumented workers. This did not pose a problem for the majority of participants who wanted to include them because they said we were currently paying for more expensive care through emergency rooms and/or it was simply the right thing to do.

LEVEL OF COVERAGE

The idea of a medical home surfaced in all councils and was viewed favorably. Each group shared a strong preference for a basic level of coverage (addressing the entire body: eyes, teeth, head, feet, etc.) coordinated through a primary care delivery model. Preventive care would be a critical element of the coverage.

Evidence-based, or care supported by the scientific community and improved health outcomes, came up in every group. Given the sophisticated level of understanding of the council members, there was recognition of this body of knowledge – and desire to make it a critical element of the coverage automatically provided in Washington state. The physicians who participated in several of the groups voiced clear support of a handful of basic care services (including but beyond preventive care) that, if provided, would significantly and positively impact the health outcomes of individuals in Washington state. Not only would these basic services be powerful in their effect, but the physicians pointed out that, if coordinated through a primary care delivery model, they could be relatively low in cost.

Many council members brought up the idea of different tiers of coverage. The first tier would be the level of coverage all would automatically receive in Washington state. The second tier could be additional coverage purchased by an individual or employer. This would allow employers to still use coverage as a recruitment and retention tool (which was a desire of some of the larger business representatives). A smaller number of council members shared the desire to get away from the tiered system we have now (those who have healthcare and those who don't).

PAYING FOR THE COVERAGE

Most members agreed that individuals, employers and government should all pay into the system.

The conversation about who would pay and how much, typically concluded with agreement that the government, employers and individuals should all pay into the system. The notion of a sliding scale (beginning with $0 for the homeless) was presented to address individual differences in ability to pay.

While a few councils brainstormed funding mechanisms, this was a difficult discussion for most. Sin and payroll taxes were the most frequently mentioned form of revenue source. A few pointed out that a sales tax would collect from anyone crossing the borders and was a way to have everyone contributing. The notion of creating a fund dedicated to healthcare (and not comingled with other state funds) was well supported by council members who were a part of the conversation in which it surfaced.

VOLUNTARY VS. GUARANTEED VS. MANDATED

Terms became important to the discussions. Making the coverage voluntary was quickly disregarded because the councils clearly understood that the more people in the pool, the more you could spread out the risk and reduce costs for those paying into the system. It appears that the council members' goal was to cover all individuals not simply to *offer* to cover all individuals.

Some didn't resist the term "mandated." Others reacted negatively and pointed out that it should be "automatic." Although much less frequent, there was a slightly negative reaction to the term "guaranteed" or "automatic" because it sounded to some that it left out the important concept of personal responsibility.

Most council members believed that the state should push forward with healthcare reform and not wait for a national solution.

NATIONAL LANDSCAPE

Most council members were hopeful that significant healthcare reform would happen at the national level within four years. While a few initial comments showed some interest in pausing to see what national efforts would produce, there was near consensus about the fact that the state should not be idle and should push forward on healthcare reform. One participant said that "the state should be shovel-ready."

Perhaps most interesting was the mixed reaction to how the economy does/should/shouldn't affect our state's actions. All three of these perspectives were present and voiced in most groups:

- We can't move forward because of the economy
- Because of the economy, we have to move forward
- **Despite** the economy, we have to move forward.

"The state should be shovel-ready."

- Civic representative

While the first comment usually surfaced initially, most agreed that either because of or despite the economy, it is necessary to take action.

WHAT PROBLEM SHOULD WE BE SOLVING IN WASHINGTON STATE? (OBJECTIVES)

Council members were asked to vote on several objectives after being given the chance to add, delete and/or modify the list. They were given five stickers to "spend," which allowed them to show emphasis where they felt strongly. They could spend all their votes on one objective or spread them across several. The more votes the objective received, the more strongly it was felt to be a problem we should be addressing in Washington state. The following objectives consistently received a high number of votes across all groups. In priority order:

- Improve health
- Reduce the cost of healthcare (system perspective)
- Ensure healthcare is affordable (from individual's perspective)
- Cover the uninsured

- Ensure access to medical care
- Reduce the burden on employers
- Take care of our citizens.

Many groups believed that there was so much waste in the current system that if a new delivery model was designed the right way, no additional money would be necessary.

BARRIERS TO CHANGE

Clearly, the lack of state funding (particularly in light of the current state deficit revealed during the second round of council meetings) and potential cost to small employers were stated as the biggest concerns and barriers for any healthcare reform in the state of Washington. Some voiced concern that the availability of coverage would drive utilization up.

Other barriers identified were:

- The notion of creating a new infrastructure (however it was repeatedly called for)
- The lack of enough primary care doctors to handle the increased demand for care
- Union contracts (a concern from business leaders)
- Insurance companies (if the Single Payer Plan went forward)
- Politics
- Anyone benefiting in the current system who may not benefit as much in the new delivery model.

"I don't think we'll increase demand – we're just shifting where the demand enters the system."

- Community representative

HOW LEADERSHIP COUNCIL FINDINGS COULD BE USED

Council members had several ideas on how the findings from these councils could be used:

- Put the information in the hands of nationally-elected officials in Washington, D.C. in addition to those in Washington state
- Arrange meetings between council representatives and policy makers to emphasize the need for action; council members want to share the sense of urgency and personally express their concerns
- Take one person from each group to form a statewide council and come up with a single recommendation.

REACTION TO PROPOSALS – ALL COUNCILS

One of the objectives of the leadership council meetings was to gather feedback and input on the five proposals under consideration by the Washington state legislature. As they discussed their recommendations, members were asked to consider the needs of Washington state residents, the national climate, the existing proposals currently being considered and the realistic barriers of passing healthcare reform.

INITIAL EXERCISES

During round one, leadership council members were asked to review the proposals at a high level. The objective was to begin to familiarize members with some of the key features of each of the proposals. Each member was given four note cards for each of the five proposals. Each card described one of the following elements:

1. Name of the plan
2. Who would be covered
3. What level of coverage they would receive
4. How the plan would be funded

They were asked to read through the proposals and share their opinions and thoughts. They commented on elements important to them, what was missing and what they didn't like and why. (Note: They were given only summary elements of the proposals – not enough detail to accurately evaluate each of the proposals, so results of this exercise are intentionally excluded in the findings.) At the end of this exercise, the participants were encouraged to create their own healthcare program – using or modifying any of the existing cards or creating new cards. These exercises satisfied our objective of getting them familiar with the proposals at a high level and successfully set a foundation for the deeper discussions on the proposals in round two.

During round one, the Single Payer and Guaranteed Health Plan were seen as more favorable than the other three proposals.

BETWEEN ROUND 1 AND ROUND 2

Members were encouraged to request information during round one that would help them better evaluate the five proposals. Members were sent answers to these questions along with additional background information in preparation for the second round of discussions. Some council members clearly used this time to improve their understanding of the five proposals.

REACTION TO MATHEMATICA PRESENTATION

During round two, members were asked to review the results of the economic analysis of the five proposals currently under consideration in the Washington state legislature. The analysis, conducted by Mathematica Policy Research under contract with the state of Washington, was not complete as anticipated in time for the second round of meetings. A draft of the presentation that summarized the analysis was provided to leadership council members prior to the second round of discussions. Instructions on how to access the Mathematica presentation were sent to members and they were encouraged to listen to it before the council meeting.

Few participants accessed the Mathematica presentation. Those who did commented that it was long, and some complained that it was confusing. In the end, it did not appear to serve as an effective way to educate participants on the economic impact of the different proposals.

PROPOSAL EVALUATION

During round two, every leadership council, without exception, voiced concern that none of the five proposals would produce the changes they felt necessary to really address the current problems. As was pointed out in the Mathematica presentation, and council members agreed, every proposal was missing the critical cost-effective and quality measures: improved health outcomes, evidence-based services, prevention and early intervention, chronic disease management, medical homes and financial incentives for providers and consumers. During both rounds of discussions, the council members spent a great deal of time emphasizing the importance of these elements.

Council members consistently voted to eliminate Private Insurance Deregulation Reform from the discussion because "it didn't go far enough."

Four out of the five proposals were favored, for one reason or another, by most of the leadership councils. Note that favoring a proposal did not mean it was acceptable as currently written but rather, compared to the other proposals, it contained desirable features or elements worthy of further discussion.

Councils were asked if there was any proposal(s) that should be eliminated so as to focus the remainder of the discussion in a productive way. While a few members in each group liked the proposal, the majority of participants voted to eliminate Private Insurance Deregulation Reform because it did too little to address the critical problems. The most common comment was that it left too many people uninsured.

SPECIFIC PROPOSAL COMMENTS

As the proposals were discussed in more depth, we captured the following comments. Rather than repeating similar comments, bold is used to show emphasis.

Positive Comments	Negative Comments
Proposal #1 (Private Insurance Deregulation Reform)	
▪ Will solve some of the problems ▪ **Would like that plans could have non-mandated benefits**	▪ **Didn't go far enough** ▪ Didn't do very much to address our objectives ▪ **Doesn't have much substance** ▪ **Negligible impact** ▪ Doesn't work from the small business perspective ▪ Provides less quality of coverage and isn't a longer term solution
Proposal #2 (Connector Plan)	
▪ Rating is a good feature	▪ Concerned that the minimum plan offered wouldn't be enough

Positive Comments	Negative Comments
▪ Might be affordable ▪ **Will solve some of the problems** ▪ Most reasonable and doable short term ▪ Like that it coordinates things that are already in place ▪ Like the concept of going to a central location regardless of the size of your organization ▪ Takes the burden off small employers ▪ Helps drive down costs but doesn't put that cost on the government	▪ Hard to accomplish ▪ Confusing ▪ Won't be particularly helpful ▪ Seems like many groups of people are excluded ▪ Not perceived as affordable (especially for low income) ▪ Doesn't address improved health objective ▪ Don't like that there's a separate benefit for state employees
Proposal #3 (Washington Health Partnership Plan)	
▪ **It's intriguing to take PEBB and Basic Health Plan participants and make this everyone's coverage** ▪ Politically palatable ▪ Provides necessary preventive care ▪ If everyone is covered, the employer would have to pay less ▪ More employers could offer coverage (even the small business would like it if not too costly)	▪ Don't know where the funding would come from ▪ Confused by who would actually be covered ▪ Doctors and insurance companies will oppose this ▪ Payroll tax is hefty ▪ Concerns about how the cost would affect small businesses
Proposal #4 (Single Payer Plan)	
▪ **Consistency of everyone being in the same plan was appealing** ▪ **Liked the fact that coverage was through the Uniform Medical Plan** ▪ Would be great	▪ **Not viable – a lack of funding mechanism** ▪ Perception is a barrier; it has a "socialism" tag ▪ Doesn't seem realistic ▪ Would be fewer battles to fight if you kept some components of

Perceptions of the Connector Plan were mixed. Many shared negative comments of the Massachusetts model, which may have influenced perceptions of the Connector Plan.

The Washington Health Partnership Plan was inviting because it folded many different groups under one plan and because PEBB coverage was perceived as comprehensive and desirable.

The Single Payer Plan was the most favored across the groups but often seen as not viable because of the lack of funding and the potential political barriers.

Positive Comments	Negative Comments
▪ Liked the consolidated system ▪ **More might support this proposal if it had a viable mechanism of funding**	the private system ▪ Not realistic due to barriers (federal waivers, cost, potential national activity)
Proposal #5 (Guaranteed Health Benefit Plan)	
▪ Step in the right direction ▪ **Good interim step** ▪ **Easiest route with the least amount of change and friction** ▪ It has value ▪ Preventive coverage gives people an incentive to come in for care on a regular basis ▪ Good to use Basic Health Plan to expand coverage to those who don't get it (300% FPL) ▪ Would have a dramatic effect on the cost of insurance [lowering costs]; could insure everyone because you'd pool everyone without much risk ▪ Everyone gets it and it takes the catastrophic burden off of everyone	▪ **Many misunderstood the $10,000 threshold** ▪ Some thought the coverage was linked to an employer ▪ It doesn't cover as many of the uninsured ▪ Don't like the $10,000 threshold because people who are uninsured won't get care ▪ **Doesn't do much for you if you're sick (needing care beyond preventive) and unemployed** ▪ Misses people who just move into the state ▪ Concerned about the cost ▪ If I tried to buy this for my employees, I couldn't afford it ▪ Concerned about excluded groups

Although there was concern that the gap between preventive and catastrophic coverage would leave some without, the Guaranteed Health Benefit Plan was seen as a good interim step.

SUMMARY OF FINDINGS – BY LOCATION

Because of the consistency of findings from one council to another, most of the findings are reported in the *Summary of Findings – All Councils* section. The following pages summarize additional findings and highlight some unique comments from or perspectives of individual councils.

CENTRAL WASHINGTON

Round 1: October 9, 2008; 16 participants

Round 2: February 5, 2009; 6 participants (This location was very remote, which led to fewer members and meant less diversity. Healthcare representatives were absent and only one civic representative attended.)

The Central Washington council favored elements of the Single Payer Plan and Guaranteed Health Plan in round one and shared preferences for the Connector Plan and Single Payer plan in round two.

One participant in round two had just returned from the healthcare conference in Washington, D.C. She was knowledgeable on the subject and had timely information. Her support for the Connector Plan and the information she shared with the group was favorably received.

"Set up a health board of experts in their field that would span administration (appointed for 10 years) above the fray and could make decisions that are politically unpopular."

- Community representative

Priorities

- Agree on a clearly-stated set of objectives in the leadership council discussion (what problem are we trying to solve?)
- Don't build on an existing program (because they're not working)
- Decisions should be influenced by data and evidence
- Personal responsibility and incentives should be built into the system
- Emphasize healthcare, not simply illness care
- Everyone pays (via a tax on consumable goods) and all residents get it
- Suggested a health tax that would go into a "locked box" so it could be used exclusively for healthcare
- "Open up the market place" and encourage insurance companies to compete for business again in Washington state (one business representative). Others (civic and healthcare representatives) did not think that the "free market forces" would solve the problems.

Concerns

- It won't be affordable for the workers when we're done
- The lack of primary care doctors (as we consider changes that would significantly increase the demand).

"When a fire department shows up at a burning house, do they ask people if they're citizens or not? What makes healthcare different?"

- Healthcare representative

COLUMBIA BASIN

Round 1: September 17, 2008; 17 participants

Round 2: March 4, 2009; 10 participants; no representatives from large or small businesses

Despite living near the Washington/Oregon border, Columbia Basin members were one of three groups generally supportive of healthcare covering people in Washington state and not limiting it to just residents. (Note that this was not complete consensus.)

This group spent some time in round one discussing a tiered healthcare system, which seemed to address some concerns. The idea of offering a basic level of care (grounded in evidence-based research) as the first tier available to all and allowing employees to buy up for additional coverage through the employers was appealing. Most agreed that the government, individuals and employers should all pay toward the basic tier.

In the first round, the Columbia Basin leadership council strongly favored features of the Single Payer Plan and Guaranteed Health Benefit Plan. In the second round, they favored features of the Single Payer Plan (with serious concerns about funding) and the Washington Health Partnership Plan (with some concerns about administering/managing it and funding).

Columbia Basin members were adamant about not recommending one of the existing proposals, even with modifications. Instead they recommended implementing a healthcare program that focused on a part of the population (for instance, children to a particular age), feeling that this was more realistic.

Priorities – eventually

- Cover all people in Washington state; mandate it (not limited to residents)
- Basic coverage, made up of evidence-based care, available to all people and individuals can "buy up" for other care; consider a tiered system
- Cover the whole body (eyes, teeth, head, etc.)
- De-link coverage from the employer
- Suggested sin tax to pay for state-wide healthcare; many also thought a sales tax would be good because everyone contributes (tourists, etc.).

Priorities – now

- Do something but start smaller; consider a broad-based system that covers everyone in a certain category and then build on it.

Concerns

- Reform that wouldn't address the core problem: the way we access care
- Taking action that would not be realistic; try to do too much and stall the reform further
- Adding costs to employers will make them unable to compete in states without the employer-paid requirement.

GREATER SEATTLE

Round 1: September 22, 2008; 21 participants

Round 2: February 25, 2009; 11 participants

While the Greater Seattle leadership council favored aspects of the Guaranteed Health Benefit Plan in both rounds of discussion, there was clear frustration that none of the proposals included the critical cost and quality elements (evidence-based medicine, the concept of a medical home, etc.). They decided, since a small step was more important than no step forward, the Guaranteed Health Benefit Plan might be acceptable if basic coverage was expanded beyond preventive care to include the critical cost and quality elements.

In their consideration of a second tier of coverage (purchased by individuals and/or employers) reaction was mixed; some saw this as a clear solution and others shared some concern that healthcare available to only a portion of the population was unfair.

The Greater Seattle leadership council was similar to the Northwest Washington council – they both emphasized that the right changes could eliminate the waste and inefficiencies in the current system, making additional funding unnecessary.

Different state healthcare plans will be particularly challenging for large businesses that have employees in many states.

Priorities

- All residents receive coverage and the government, employers and individuals (on a sliding scale) pay toward it
- Primary care should be delivered by a clinical team, use evidence-based research and address the whole patient (must integrate dental and mental health)
- Integrated, comprehensive mandated healthcare
- Equitable (does not favor one category of people over another)
- Pooling small business populations.

Concerns

- Dealing with state-by-state differences in healthcare for larger businesses with employees in many states
- Any of the five proposals are just Band-Aids because they don't change the way care is delivered and the way providers are reimbursed
- Payment for providers and the way the money would flow in the healthcare system.

"Offering healthcare state-wide would attract business to our state and make us more competitive."

- Business representative

NORTHWEST WASHINGTON

Round 1: September 30, 2008; 15 participants

Round 2: March 3, 2009; 8 participants

During round 1, the Northwest Washington council favored the Connector model and, as a second choice, split between the Washington Health Partnership Plan and the Guaranteed Health Benefit Plan. During round 2, they shifted their focus to the Washington Health Partnership Plan and the Guaranteed Health Benefit Plan (and away from the Connector Plan).

This was the only council to eliminate the Single Payer Plan (along with the Private Insurance Deregulation Reform) from discussion. Many commented that while the Single Payer Plan was a desirable option, they did not perceive it as realistic. According to one member, it would require waivers from the federal government. Others were expecting national change and supported an interim step at the state level.

A few members in this council were particularly knowledgeable about national healthcare in other countries and discussed the advantages of other countries' healthcare systems.

Most of the members in the second round of discussion agreed that offering healthcare state-wide would allow us to attract business to our state and be more competitive. Similarly, they suggested that American workers could return to global competitiveness should national healthcare be realized.

Priorities

- Basic level of coverage automatically provided to all in Washington state; supported the idea of buy-up or additional coverage purchased by individuals or employers
- Basic coverage must use the best practices in a medical home model
- De-link coverage from the employer and cover everyone
- More likely than any group to suggest building on an existing program and "tweaking something that is already working well"
- Fold in the other programs (Basic Health Plan, PEBB, etc.) under one system
- Include those eligible for Medicare to improve their access to care (physicians).

Concerns

- Affordable for the individual but also reasonable for the provider
- Suggesting a program that would mean too much change (as would be the case with the Single Payer Plan) that it would not allow reform to go forward.

OLYMPIC PENINSULA

Round 1: September 10, 2008; 18 participants

Round 2: February 11, 2009; 14 participants

Olympic Peninsula leadership council members were strongly in favor of the Single Payer Plan (during both round one and round two) to such a degree that they were the only group to achieve complete consensus on their favorite plan. Instead of trying to modify the plan, they were interested in talking about what needed to happen to ensure it gets implemented. We had a lengthy discussion of how to break down these barriers: funding, push back from insurance companies, increased demand for/lack of available physicians, transfer of administrative role (now the State), convincing people to trust the State, union issues and undocumented adults and children.

Olympic Peninsula Leadership Council had 100% agreement favoring the Single Payer Plan.

Many members in the Olympic Peninsula council believed that more money is not required to implement the Single Payer Plan – we would just need the money to "flow" differently. Some savings could be realized by avoiding waste and inefficiencies, they said. There was recognition that there would be the most resistance by parties in the system that are currently benefiting who wouldn't benefit as much after the Single Payer Plan is implemented.

A smooth transition to the new system was important to Olympic Peninsula council members. There was interest in mapping out the current and future systems to get a more transparent view of who would gain and who might lose. Where does the money flow now and how would it flow in the new system?

Priorities

- State-administered healthcare; one system
- Cover all residents after 12 months (before this option is available, they could buy non-subsidized coverage); exclude those covered under federal programs
- Mandate coverage
- Coverage "moves with the individual" and not linked to the employer
- Care must be coordinated (medical home); offer more than catastrophic and preventive (holistic); be evidence-based
- Everyone pays something.

Concerns

- Burden on small employers or businesses
- Concerns about how to fund the Single Payer Plan
- Large employer representative had concerns about union issues.

SOUTH SOUND

Round 1: September 17, 2008; 19 participants

Round 2: October 29, 2009; 10 participants

The South Sound leadership council clearly favored the Guaranteed Health Benefit Plan during round one. When one person described the $10,000 threshold as a deductible, the other participants said they would significantly lower their rating of the Guaranteed Health Benefit Plan. This is important because it shows how terminology can change opinions. When the threshold was described accurately, the proposal was supported. When the term deductible was used (inaccurately describing the feature), opinions of the plan became more negative.

"The fact that you get UMP coverage makes me more supportive of the Single Payer Plan."

- Healthcare representative

Council members favored features and concepts in the Washington Health Partnership Plan and Single Payer Plan during the second round and after learning more about the proposals. Members were particularly pleased to learn that the favored proposals would offer the state coverage (many liked the Uniform Medical Plan).

In part to maintain employer choice to offer coverage, this council made a distinction between two tiers of coverage: a basic level of services automatically provided and paid by all (individuals, government and employers) and an additional tier that was optional or additional coverage. Not everyone was supportive that healthcare should be used as a way for businesses to be more competitive.

Priorities

- Everyone has access, including those in federal programs
- Some business representatives felt it was important to be a resident (have a Washington state driver's license) to get coverage; civic and healthcare members were more likely to eliminate a residency restriction.
- Everyone pays something (state, federal, employer and individual)
- Preventive care and catastrophic coverage.

Concerns

- Giving up choice and the ability to distinguish the business (from a business representative).

SPOKANE VALLEY

Round 1: October 8, 2008; 15 participants

Round 2: February 6, 2009; 11 participants

The Spokane Valley leadership council was very engaged and had a high level of energy about the topic of healthcare. They were so interested in exploring this issue that they exchanged email addresses during the first meeting. The members tended to be knowledgeable of the proposals and not shy about sharing their opinion that none of the proposals, as they were currently written, accomplished their goals.

During round two, after they had become more familiar with the proposals, the majority of the group wanted to discuss the Single Payer Plan and the Washington Health Partnership Plan. This was the only group to shift their focus completely (after initially favoring the Guaranteed Benefit Plan and the Connector Plan).

Spokane Valley was concerned with the idea of implementing another healthcare plan when the focus should be on fixing the "system."

Perhaps with even more passion than other councils, Spokane Valley members believed preventive care, education and incentives were critical to a successful healthcare program.

Priorities

- Change people's thinking – focus on health; create a healthcare model that focuses on staying healthy and not just caring for the ill and injured
- Everyone in Washington state should be in one pool to reduce costs
- Everyone should pay (individuals, employers and government)
- Incentives for individuals and small businesses
- Incentives for people to stay healthy.

Concerns

- Not one of the five proposals solves the issues – they're all Band-Aids.
- Don't try to create another plan; change the system

GEOGRAPHIC DIFFERENCES

Perceptions and opinions of council members were surprisingly consistent. Patterns were more detectable by sector than by geographic location.

COMMUNITY SECTOR DIFFERENCES

HEALTHCARE

Healthcare representatives included administrators from hospitals and clinics as well as providers (nurses and physicians). These representatives were more likely to make the following comments:

- The medical home would be a successful model
- The administrative burden is being shifted to providers
- Coordinated care with less administration would be well-received
- Catastrophic plans are difficult for providers because the onus is on us to collect the high deductible
- Insurance companies add an unnecessary layer of costs
- Providers consistently using standards of care would improve healthcare quality
- Access to health insurance doesn't guarantee access to effective healthcare [concerns about lack of coordinated care and the shrinking number of providers]
- Incentives could play an effective role in a new healthcare system
- Coordinating care through a primary care model makes sense
- There's less concern about increasing utilization because by providing the right care at the right time and with the right resources, we'll save money in the long run

LARGE EMPLOYERS

Representatives from larger employers shared some concern about losing their ability to attract and retain workers if healthcare was offered in Washington state. Many want to continue to offer coverage to employees but at a much more reasonable cost. A second tier of coverage that employers could still offer seemed to address some of their concern.

Two of the largest employers who participated recognized the potential administrative difficulties that would come along with communicating to employees in different states (that have different healthcare systems).

Union contracts became a perceived barrier for large business representatives who didn't know how to think about Washington healthcare

for everyone given an active union base. They tended to think it might not apply because they assumed the coverage offered wouldn't be as comprehensive as that which had been bargained.

SMALL EMPLOYERS

Employers with a small number of employees talked most often of concern about the potential cost burden and the desire to pool their employees with other small businesses.

CIVIC AND COMMUNITY

Civic representatives included city managers, council members and others in elected public office. Community representatives included but weren't limited to: members from labor councils, associations, charity organizations and local tribes. Comments from civic and community representatives commonly addressed the need to educate people on:

- How to get and stay healthy
- The availability of care
- The importance of getting appropriate care.

Civic and community representatives pointed out that you can build the most amazing healthcare system and, it will be for nothing, if you don't help people understand how important it is and how to take advantage of it. Large employer representatives tended to agree with these comments on education as they surfaced.

ABOUT MILLIMAN

Milliman, whose corporate offices are in Seattle, serves the full spectrum of business, financial, government and union organizations. Founded in 1947 as Milliman & Robertson, the company has 49 offices in principal cities in the United States and worldwide. Milliman employs more than 2,100 people, including a professional staff of more than 1,100 qualified consultants and actuaries. The firm has consulting practices in employee benefits, healthcare, life insurance/financial services and property and casualty insurance. Milliman's employee benefits practice is a member of Abelica Global, an international organization of independent consulting firms serving clients around the globe. For further information visit Milliman.com.

DENISE FOSTER, MILLIMAN

Principal, Employee Communication

CURRENT RESPONSIBILITY

Denise is the practice leader of the Employee Communication department in the Seattle office of Milliman. She joined the firm in 2005, after 10 years with Mercer.

EXPERIENCE

Denise has 18 years of experience in employee communication. Specific areas of expertise include healthcare, retirement and employee research. She has advised organizations in both the public and private sector, many with significant union presence.

Throughout her consulting experience, Denise has facilitated public sessions, employee focus groups and project teams. Her related experience includes:

- Strategy and planning
- Group facilitation
- Participant communications
- Key stakeholder analysis
- Analysis and synthesis of participant data
- Presentation of findings
- Recommendations and action steps.

Denise is well-versed in healthcare issues and the challenges and complexities of the public sector. Relevant projects include:

- Developing the strategy and conducting sessions with 90 small business owners (and small business employees without healthcare) to understand the owners' appetite and tipping point for offering government-subsidized healthcare as well as the plan designs and costs that would be most appealing to employees
- Participating in the initial task force meetings that eventually became the Puget Sound Healthcare Alliance (prior to Milliman)
- Conducting focus groups for a public sector client to gather feedback on written materials and demonstrate a newly developed Web site
- Setting strategy to engage employees around healthcare issues and introduce tools and resources so employees can make active, informed decisions
- Introducing a consumer-directed health plan to active employees and retirees through a series of newsletters and enrollment materials
- Setting strategy and conducting research with the goal of increasing participation in the new wellness program for 90,000+ members.

EDUCATION

- BA, Communication, University of Colorado
- BA, Psychology, University of Colorado
- MA, Interpersonal and Organizational Communication, University of Washington

Denise is a member of the International Association of Business Communicators